	R MEDICARE & MEDIC						1B NO. 0938-0391
f ·		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155729	B. WING			08/02/2011	
NAME OF S	DD OLUDED OD GUDDU IEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	K	12011 WHITTERN RD				
VILLAGE	OF HERITAGE, T	HE		MONRO	DEVILLE, IN46773		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATF.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG DEFICIENCY)			DATE
F0000							
	This visit was for investigation of		FC	0000	8/15/11Ms. Kim Rhoades,		
	Complaint Num	ber IN00093942.			Director of Long Term		
					CareIndiana State Departme Health2 North Meridian	ent or	
	Complaint Num	ber			StreetIndianapolis, IN 46204	1Dear	
	1 ^	bstantiated. Federal/state			Ms. Rhoades, Enclosed is T		
		ated to the allegations are			Village of Heritage's Plan of		
	cited at F 223 ar	<u> </u>			Correction for our complaint		
	Citcu at 1 223 at	lu 1 220.			survey on August 2, 2011.TI		
		. 1 2 2011			Village of Heritage is requesting		
	Survey dates: August 1, 2, 2011				paper compliance for F223, D; and F226, SS:D.The atta		
					plan of correction is our cred		
	Facility number:				allegation of		
	Provider number	r: 155729			compliance.Preparation and	l/or	
	Aim number: 20	00289420			execution of this plan of		
					correction in general, or this		
	Survey team:				corrective action in particula		
	Ann Armey, RN	I TC			does not constitute an admi or an agreement by The Vill		
	Ellen Ruppel, R				Heritage of the facts alleged		
	Ziion reappoi, re	- 1			conclusions set forth in the		
	Census bed type	•			statement of deficiencies. T		
	SNF/NF: 59	·•			plan of correction and speci		
					corrective actions are prepa		
	Total: 59				and/or executed in compliar with State and Federal	ic c	
					laws.Sincerely,Stephanie D.		
	Census payor ty	pe:			Allen, HFAAdministrator		
	Medicare: 6						
	Medicaid: 34						
	Other: 19						
	Total: 59						
	Sample: 4						
	1	ies reflect state findings					
	cited in accordar	nce with 410 IAC 16.2.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

WU5D11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155729	A. BUII B. WIN			08/02/2	011
	PROVIDER OR SUPPLIER E OF HERITAGE, TH		STREET ADDRESS, CITY, STATE, ZIP CODE 12011 WHITTERN RD MONROEVILLE, IN46773				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0223 SS=D	verbal, sexual, phy corporal punishment seclusion. The facility must in sexual, or physical punishment, or invited Based on observation record review, the aresident was from instreatment by (Resident #B). To of 1 residents, remistreatment in a #C) Findings included During interview the Administrator Resident #B was room with his he According to the cameras had record entrance into the his removal from The Administrator had no prior sexual indicated, after the was placed on 15 transferred to a better the second of	the right to be free from visical, and mental abuse, ent, and involuntary of use verbal, mental, labuse, corporal voluntary seclusion. Action, interview and the facility failed to assure the from sexual another resident. This deficiency affected 1 viewed for sexual another sexual another sexual another resident. This deficiency affected 1 viewed for sexual another sexual another resident. This deficiency affected 1 viewed for sexual another resident. This deficiency affected 1 viewed for sexual another resident. This deficiency affected 1 viewed for sexual another resident another resident. This deficiency affected 1 viewed for sexual another resident another resident. This deficiency affected 1 viewed for sexual another resident #B and between her legs. Administrator, hall bridged Resident #B and behaviors. She are incident, Resident #B and behaviors. She are incident, Resident #B	FC	223	1.What corrective actions will accomplished for those reside found to have been affected the deficient practice? Resice B was sent to Behaviorial Her for evaluation. Residents Bar C will be monitored weekly x weeks and monthly x 6 mont Social Services. (Addendum How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? A door alarm was place on Resident door. (Addendum B). All other residents in the facility were interviewed on 7/19/11 by the MDS coordinator and DON regarding any concerns with residents entering your room unwanted or having any trou with other residents. There we no concerns voiced. (Adden C) All residents residing in the facility are interviewed with a quarterly Abuse Prohibition Interview that is completed in accordance with the MDS schedule. (Addendum D)3. What measures will be put in	ents by dent ealth and 4 hs by A)2. he e e t B's er e ble were dum ne	09/01/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		155729	B. WIN			08/02/2	011
		I	B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		1	VHITTERN RD		
VII I AGE	E OF HERITAGE, T	HE		1	DEVILLE, IN46773		
					52 1122, 11 10770		
(X4) ID		STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION	
TAG	 	R LSC IDENTIFYING INFORMATION)	+	TAG		~~~	DATE
	Administrator indicated Resident #C was				place or what systemic changes will be made to ensure that the		
	1	d no physical injuries. The			deficient practice does not re		
	1	restigated and reported to			Resident B is being followed		
	the ISDH (India	na State Department of			the facility behavior manager	ment	
	Health).				doctor and by the MSW.		
	On 8/1/11 at 2:00 P.M., accompanied by LPN #1, Resident #B was observed in his				(Addendum E) Resident B is		
					15 minute checks throughou day, and has a door alarm th		
					on at night, with function che		
	room in bed. A motion alarm was on the				on night shift. (Addendum F		
	door.				Resident B was started on	,	
	During interview at that time, LPN #1				Lexapro and Risperdal.		
	indicated the door alarm was turned on at				(Addendum G)4. How will th		
	indicated the door alarm was turned on at 10:00 P.M. and would alert staff if				corrective actions be monitor ensure the deficient practice		
					not recur? Resident B and C		
		his room during the			be monitored weekly x 4 week		
	~	was checked by LPN #1			and monthly x 6 months by S		
	and was working	g.			Services with results to QA.		
					Abuse prohibition quarterly		
	On 8/1/11 at 2:3	0 P.M., the clinical record			interview results will be moni by the administrator or desig		
	of resident #B w	as reviewed and indicated			with results to QA x 6 months		
	the resident was	admitted to the facility on			In compliance by 9/1/11.	3.0.	
	11/17/10, with d	liagnoses which included					
	but were not lim	ited to, Alzheimer's					
		ia and depression.					
	The MDS (Mini	•					
	1	ed 5/5/11, indicated the					
		ere cognitive impairment					
	1	ident with transfer and					
	ambulation.	ident with transfer and					
		a mandamittad to the feetilite.					
	1	s readmitted to the facility					
	from the behavioral unit on 7/28/11.						
	The clinical reco	ord of Resident #C was					
	reviewed on 8/1.	/11 at 2:30 P.M. and					
	indicated the res	sident was admitted to the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155729		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED 08/02/2011		
		155729	B. WIN			08/02/2	011
NAME OF	PROVIDER OR SUPPLIEI	₹		1	ADDRESS, CITY, STATE, ZIP CODE		
VILLAGE	OF HERITAGE, TI	HE		1	VHITTERN RD DEVILLE, IN46773		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	1	0 with diagnoses which					
	included but were not limited to						
		ease and psychosis.					
		sment, dated 4/14/11,					
		ident had severe cognitive					
	_	was independent with					
	transfers and am	bulation.					
	On 8/1/11 at 3:2	0 P.M., Resident #C was					
	interviewed. She indicated she had no fear						
	of anyone, and no one had been inappropriate with her.						
	'' '						
	The investigation	n of the incident was					
	reviewed on 8/1	/11 at 3:30 P.M.					
	A statement from	n CNA #2, dated 7/19/11,					
	indicated she wa	s doing her rounds and					
	heard noises like	e snoring so she turned on					
	the light in Resid	dent #C's room and saw					
	someone bent ov	ver Resident #C. CNA #2					
	1	ut off the light to go get					
	the nurse and the	en went back to Resident					
		uble check what she had					
		turned on the light I then					
		e was doing a sexual					
	'	ent #C's name). I went to					
	1 -	urses name) I got the					
	` ′	ld her someone was					
	1 *	ng (Resident #C's name)					
	` ′	turned on the light he					
	_	nurse & I went into					
	`	ame) room & (and)					
	,	nt #B's name) arm &					
	(and) told him h	e had to stop & (and) go					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	155729	A. BUI		00	08/02/2	
		100720	B. WIN		DDDEGG CITY GTATE ZID CODE	00/02/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE WHITTERN RD		
VILLAGE	OF HERITAGE, TH	I E		1	DEVILLE, IN46773		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
	back to his room" The statement indicated she had seen						
		ne hall earlier and he said					
	weather.	the door to check the					
	weather.						
	LPN #3's stateme	ent indicated CNA #2					
	came and got her	and they went to					
		om and found Resident					
	#B's head betwee	en Resident #C's legs in					
	her pubic area. Resident #B was "licking						
		sing that area. She was					
	1 ' ' '	still" The statement					
	l .	, after Resident #B was					
		n, she the CNA went back					
		dent #C. "She said she					
		ed our hands et (and) said					
	'thank you' sever	al times"					
	On 8/1/11 at 4:30	P.M., the Administrator					
	was interviewed	regarding why the aide					
	had not immedia	tely intervened to protect					
	Resident #C. The	e Administrator indicated					
	she had noted the	e CNA did not intervene					
	immediately and	all staff had been					
	inserviced follow	ving the incident.					
		or further indicated, all					
	staff, including C	CNA #2, had attended an					
	inservice on 5/11	/11, that included abuse					
	training.						
	On 8/2/11 at 4·4·	5 A.M., CNA #2 was					
		indicated she was so					
		she had seen that she					

AND PLAN OF CORRECTION IDENT		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155729	(X2) MULT A. BUILDI B. WING		OO	(X3) DATE S COMPL 08/02/20	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 12011 WHITTERN RD MONROEVILLE, IN46773					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE	
F0226 SS=D	incident was revial Administrator and seconds elapsed in CNA first checked and the nurse entire This Federal tag Number IN00092 3.1-27(b) The facility must distribute and misappropriate Based on observative record review, the staff intervened in resident who was another resident who was another resident who was another resident who was another resident of the ficiency affector reviewed for sexus sample of 4. (Resident intervened in the Administrator interviewed for sexus sample of 4. (Resident interviewed for sexus sample interview	evelop and implement d procedures that prohibit lect, and abuse of residents ion of resident property. Ation, interview and e facility failed to assure mmediately to protect a seeing mistreated by (Resident #B). This led 1 of 1 residents, and mistreatment, in a sident #C)	F022	26	1. What corrective action will accomplished for those resid found to have been afffected the deficient practice? CNA: was educated regarding immediately intervening in possible abuse situations. (Addendum H)2. How other residents having the potential be affected by the same defic practice will be identified and what corrective action was taken? All staff was provided paper inservice Abuse Refres on 7/21/11, reminding to staff stay with the resident, keep the safe, and call for help.	ents by #2 I to cient d a sher f to	09/01/2011	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WU5D11 Facility ID:

002549

If continuation sheet

Page 6 of 11

l l		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155729	B. WIN			08/02/2	U11
NAME OF	PROVIDER OR SUPPLIE			1	ADDRESS, CITY, STATE, ZIP CODE		
			12011 WHITTERN RD				
VILLAGI	E OF HERITAGE, TI	HE	MONROEVILLE, IN46773				
(X4) ID		MARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	room with his head between her legs.				(Addendum I)3. What measures will be put into place or what		
		e Administrator, hall			systemic changes will be mad	de to	
		orded Resident #B's			ensure that the deficient prac		
	entrance into the	e room at 3:11 A.M. and			does not recur? Policy and		
	his removal fron	n the room, at 3:21 A.M.			procedure was updated to sa		
	The Administrat	or indicated Resident #B			stay with resident and keep t		
	had no prior sexual behaviors. She indicated, after the incident, Resident #B was placed on 15 minute checks, transferred to a behavior center, and had recently returned to the facility. The				safe, call for help. (Addendu Policy and Procedure will be		
					inserviced by August 25, 201		
					How the corrective action wil	l be	
					monitored to ensure the defici	cient	
					practice will not recur? Administrator or designee will		
	Administrator indicated Resident #C was assessed and had no physical injuries. The				randomly question 5 staff	II	
					members each month for 6		
	1	estigated and reported to			months about what they wou	ld do	
		na State Department of			in an abuse situation with res		
	Health).	na State Department of			to QA.5. In compliance by 9	/1/11.	
	Ticaiui).						
	On 9/1/11 of 2:0	0 P.M., accompanied by					
	1						
	1	nt #B was observed in his					
		notion alarm was on the					
	door.	. d . d . T 753 T #4					
	1 -	v at that time, LPN #1					
		or alarm was turned on at					
		would alert staff if					
	1	his room during the					
	night. The alarm	was checked by LPN #1					
	and was working	g.					
	On 8/1/11 at 2:3	0 P.M., the clinical record					
	of resident #B w	as reviewed and indicated					
	the resident was	admitted to the facility on					
	11/17/10, with diagnoses which included						
	1	ited to, Alzheimer's					
		a and depression.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
AND PLAN	OF CORRECTION	155729	A. BUI	LDING	00	08/02/2	
		133729	B. WIN			00/02/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
VILLAGE	OF HERITAGE, TH	łF		1	VHITTERN RD DEVILLE, IN46773		
					52 VILLE, II VIO 170		(2/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	The MDS (Minimum Data Set)						
	assessment, dated 5/5/11, indicated the						
	l '	ere cognitive impairment					
		dent with transfer and					
	ambulation.	W-110 1/1111 01-0111112-0-1 Will W					
		readmitted to the facility					
		oral unit on 7/28/11.					
		- WI WILL OH 1/20/11.					
	The clinical reco	rd of Resident #C was					
		11 at 2:30 P.M. and					
	indicated the resident was admitted to the facility on 3/1/10 with diagnoses which						
	included but wer	_					
		ase and psychosis.					
		ment, dated 4/14/11,					
		dent had severe cognitive					
		was independent with					
	transfers and aml						
	transicis and ann	outation.					
	On 8/1/11 at 3·20	P.M., Resident #C was					
		indicated she had no fear					
	of anyone, and no						
	inappropriate wit						
	mappropriate wit						
	The investigation	of the incident was					
	reviewed on 8/1/						
		n CNA #2, dated 7/19/11,					
		s doing her rounds and					
		snoring so she turned on					
		lent #C's room and saw					
	_	er Resident #C. CNA #2					
		at off the light to go get					
		n went back to Resident					
		ible check what she had					
		ioto officer what she mad					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155729		(X2) MULTIPLE C	(X3) DATE SURVEY COMPLETED 08/02/2011		
	PROVIDER OR SUPPLIER		12011	ADDRESS, CITY, STATE, ZIP CODE WHITTERN RD	
VILLAGE OF HERITAGE, THE			MONE	ROEVILLE, IN46773	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
	realized someone action to (Reside get the nurse. (nu nurse & (and) tol sexually attackin & (and) when I to didn't stop. The resident #C's na grabbed (Resider (and) told him he back to his room The statement in Resident #B in the was going to toweather. LPN #3's statemed came and got her Resident #C's room #B's head between her pubic area. Ror sucking or kisslying there very suffurther indicated, taken to his room to check on Resident was okay, grabbed 'thank you' several on 8/1/11 at 4:30 was interviewed had not immedia	ent indicated CNA #2 rand they went to om and found Resident en Resident #C's legs in resident #B was "licking sing that area. She was still" The statement after Resident #B was n, she the CNA went back dent #C. "She said she ed our hands et (and) said			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155729		(X2) MULTIPLE C A. BUILDING B. WING	00	COMP	(X3) DATE SURVEY COMPLETED 08/02/2011	
	PROVIDER OR SUPPLIEF		12011	TADDRESS, CITY, STATE, ZIP CO WHITTERN RD ROEVILLE, IN46773	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	immediately and inserviced follow The Administrat staff, including O	e CNA did not intervene all staff had been ving the incident. or further indicated, all CNA #2, had attended an 1/11, that included abuse				
	interviewed. She	5 A.M., CNA #2 was indicated she was so she had seen that she urse and did not				
	On 8/2/11 at 5:45 A.M., the video of the incident was reviewed with the Administrator and one minute and twenty seconds elapsed between the time the CNA first checked Resident #C's room and the nurse entered the room.					
	and Protection o policy for "Abus 5/11/11, was pro Administrator ar the policyto as facility are free f physical and men punishment and It shall be the po	ad indicated "It shall be sure all residents of this from verbal, sexual, ntal abuse, corporal involuntary seclusion licyto assure the safety volved during and after				

002549

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155729		(X2) MULTIPLE CC A. BUILDING B. WING	00	i .	E SURVEY PLETED 2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 12011 WHITTERN RD MONROEVILLE, IN46773					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
	5/11/11 inservice at 6:00 A.M. and Responsible to In Resident Should Abuse/Neglect -You must stay we for assistance"	vith the resident and call relates to Complaint						